CHILDREN AND HOOSIER IMMUNIZATION REGISTRY PROGRAM (CHIRP)
VACCINE ADMINISTRATION
RECORD OF PARENT/GUARDIAN OR RECEIPT SIGNATURE

I have read or had explained to me the information in the 'Vaccine Information Statement(s)" or the "Important Information Statement(s)" for the disease(s) and vaccine(s) checked below. I have had a chance to ask questions and fully understand the benefits and risks of the vaccine(s) checked below. I request that these vaccines be given to me or to the person named below.

☐ DT ☐ Tdap ☐ Td ☐ DTaP ☐ DTaP-HIb ☐ DTaP/HepB/IPV ☐ Hib ☐ IPV ☐ MMR ☐ Varicella ☐ HEP B ☐ Hib/Hep B ☐ PCV-13 ☐ MCV4
☐ DTaP-IPV ☐ DTaP/IPV/Hib ☐ Influenza .25ml or .50ml ☐ MMR/Varicella ☐ HEP A ☐ Rotavirus ☐ HPV
☐ Flu Mist
☐ H1N1
☐ HepA/HepB (Adult)

Last Name:	First:		Middle:	Patient ID:	Patient SSN*:
Date of Birth:	Age:	Birth State:	Birth Country:	Hoosier Hwise #-	Gender: O M O F
Race: O White O African American O Asian O Multi-racial O Other O Nat. Hawaiian, Pac. Isl. O American Indian				Hispanic Origin: O Hispanic O Non-Hispanic O Unknown	
Physician Name:			School:		
Guardian 1 Last Name:	First:		Middle:	Guardian 1 SSN*:	
Guardian 2 Last Name:	First:		Mother Maiden Name:		
Mailing Address for Responsible Adult: O Mother O Father O Other (specify) _____					
Last Name:			First Name:		
Address:			Home Phone:	Work Phone:	
City:	State:	ZIP Code:	Email Address:		
Language, if other than English (specify):			Other Phone (specify):		
(Clinic use only)	Chart Number				

Funding Source: O Medicaid O Uninsured O Nat. American or Alaskan
O Underinsured - FQHC or RHC Only O Hoosier HWise Pkg C O Ineligible
O State Funded

• Social Security numbers may be used to identify patient and family members and are optional on this form There are no penalties for failure to provide Social Security numbers.

Signature of person to receive vaccine(s) or person authorized to consent to the immunizations(s)

_____
Parent/Guardian Signature

_____ _____
Printed Name Date